| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 005002 | A. BUILDING: _____ B. WING _____ | 10/21/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| METHODIST HOSPITALS INC | 600 GRANT ST GARY, IN 46402 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S 000 | INITIAL COMMENTS<br><br>This visit was for the investigation of two (2) State complaints.<br><br>Complaint number IN00145848<br>Substantiated; no deficiencies related to the allegations are cited.<br><br>Complaint number IN00146307<br>Unsubstantiated; lack of sufficient evidence.<br><br>Date of survey: 10/21/2014<br><br>Facility number: 005002<br><br>Surveyor: Nancy Otten, RN<br>Public Health Nurse Surveyor<br><br>Methodist Hospitals, Inc. is in compliance with 410 IAC 15-1.5-1, Dietetic services, 15-1.5-5, Medical staff, 15-1.5-6, Nursing service and 15-1.6.2, Emergency services, Hospital Licensure Rules.<br><br>QA: claughlin 11/20/14 | S 000 | | |